



Pell City Office
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Fax 1-205-884-7928

Home Office
P.O. Box 71335
Des Moines, IA 50325
(888) 221-1234
Fax 1-515-221-0138

www.american-equity.com

Policy # _____

Insured _____

POLICY REINSTATEMENT FORM

APPLICATION WITHOUT EXAMINATION FOR (Check One)

- () Reinstatement () Additional Benefits () W.P. () D.I. () Payor () Additional Insurance
() Request for extension of time beyond 60 days

Full Name of Insured (please print) _____

I hereby request _____

All communications should be sent to the address shown below:

Street & Number or R.F.D.	City or Town	Country	State & Zip

STATEMENT OF PRESENT HEALTH OF INSURED, INCLUDING ANY DEPENDENTS WHO WERE INSURED UNDER THE ABOVE - NUMBERED POLICY.

For Individual policy, give details for insured only. For Child policy with Payor Benefit, give details for both child and owner (payor). For Family group, life or hospital, give details for applicant and all dependents.

	INSURED		OTHER FAMILY MEMBERS			INSURED		OTHER FAMILY MEMBERS	
	Yes	No	Yes	No		Yes	No	Yes	No
So far as you know and believe:									
1. Are you, and all dependents insured under this policy, now in good health and free from impairment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Been declined, postponed, or limited for any life, accident or health insurance or reinstatement thereof?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Since date of this policy, have you or any dependents:					d. Applied for any such insurance in any Company?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Suffered any sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
b. Consulted or been treated by any physician or practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Name of each illness, disease, etc.	Attacks No./Date	Duration	Complications or after effects	Date of complete recovery	Name and address of each Physician or Practitioner				

3. Please give exact height and weight at present.
Insured: Height _____ Lbs _____ Dependents/Spouse: Height _____ Lbs _____
4. Is any female applicant or dependent now pregnant or had any miscarriages or female disorder? _____
5. Occupation? _____
a. Duties (Include those pertaining to any other occupation) _____

- b. Firm name and title _____
6. Have you operated or ridden in or do you contemplate operating or riding in any kind of aircraft, EXCEPT as a passenger on regular scheduled passenger lines? ____ YES ____ NO (If answered "yes" we will send you an aviation form to be filled out.)
7. Average earned monthly income? \$ _____
(To be answered only when the policy provides for loss of time from either accident or sickness or both.)

I certify that the answers to the questions and the statements made herein are true and complete and are offered to the Company as an inducement to _____
I agree that this application shall be of no effect unless and until finally approved by the Company, and unless and until the required premium or other cost has been paid during my good health.

AUTHORIZATION: I hereby authorize any physician, hospital, clinic, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or of any member of my family or my (our) health, to give this requested information to American Equity Investment Life Insurance Company. A photographic copy of this authorization shall be valid as the original. I also acknowledge receipt of the (Important Notice Form).

Dated at _____ this _____ day of _____ Year _____
City, State

X _____ X _____
Witness Signature of Insured